Department of Human Resources
Division of Employee Benefits

2021 OPEN ENROLLMENT FORM

Use this enrollment form to *CHANGE* or *DECLINE* your medical insurance for the 2021 plan year. Please **Do Not Return** this form if you are not making any health insurance changes. You will **automatically** remain in the current insurance that you have.

EMPLOYEE INFORMATION		
NAME	**SOCIAL SECURITY NUMBER**	
ADDRESS (No PO Boxes)	**PHONE NUMBER**	
	BIRTH DATE	
CITY	**STATE**	**ZIP CODE**

MEDICAL INSURANCE SELECTION

***If you are **NOT** making changes to your Medical Plan you do **NOT** need to return this form. If you are making changes, please select the alternative Medical Plan and return this form to the address listed on the bottom of this page.

Medicare Eligible Retirees:

1) Are you enrolling in a Medicare Advantage Plan not sponsored by Milwaukee County? ☐ Yes ☐ No
2) Are you enrolling in a Part D prescription plan not sponsored by Milwaukee County? ☐ Yes ☐ No

If you answered "**Yes**" to either of these questions you must enroll into the UHC Choice Plus Plan
If you answered "**No**" to both of these questions you can enroll into the Medicare Advantage Plan

Choose your plan: (Please note that you and your dependents may be in different plans)
☐ **Medicare Advantage – (must be Medicare Eligible)**

☐ Retiree – (On Medicare) ☐ Spouse – (On Medicare)

☐ Retiree and Spouse – (Both on Medicare)

-OR-

☐ **UHC Choice Plus Plan (PPO Comparable)**

☐ Retiree only ☐ Spouse only ☐ Retiree + Spouse

☐ Retiree or Spouse + Child(ren) ☐ Family

☐ **Waive** - If you elect to waive coverage at this time, you will **NOT** be eligible to re-enroll in medical at a later date.

COURTHOUSE ROOM 210 901 NORTH 9TH STREET, MILWAUKEE, WI 53233
PHONE: 414-278-4198 FAX: 414-223-1379

As of January 1, 2011, the Centers for Medicare & Medicaid Services (CMS), a federal government agency, require eligibility data sent to UnitedHealthcare to include social security numbers of all individuals covered under any Milwaukee County medical plan**. Please include the social security number for any newly covered dependents.** Please list demographic information with entire Social Security Number for all new dependents.

YOUR MEDICAL DEPENDENTS				
Name	**Date of Birth**	**Social Security Number (Required)**	**Relationship**	**Gender**
			☐ Spouse ☐ Child	☐ M ☐ F
			☐ Spouse ☐ Child	☐ M ☐ F
			☐ Spouse ☐ Child	☐ M ☐ F
			☐ Spouse ☐ Child	☐ M ☐ F
			☐ Spouse ☐ Child	☐ M ☐ F

MILWAUKEE COUNTY GROUP LIFE INSURANCE

Update Information or cancel coverage

☐ **Cancel Coverage** ☐ **Name Change** - Former Name: _____

☐ **Change of Beneficiary: I hereby designate the following as beneficiary or beneficiaries:**

Full Name	Date of Birth	Relationship	Share %	Primary/Contingent
_____	___/___/___	_____	_____	_____
_____	___/___/___	_____	_____	_____
_____	___/___/___	_____	_____	_____
_____	___/___/___	_____	_____	_____
_____	___/___/___	_____	_____	_____
_____	___/___/___	_____	_____	_____

I am confirming that all information is represented accurately, and that dependent/s listed on my record are eligible for coverage under the terms of Milwaukee County's benefit plans. I understand I may be required to provide verification of all information contained within my enrollment record.

Signature	Date